Form Approved
OMB No. 0920-0666
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# Hemovigilance Module
# Adverse Reaction
# Transfusion Associated Dyspnea

*Required for saving

*Facility ID#: _____ NHSN Adverse Reaction #: _____

## Patient Information

***Patient ID:** _____ ***Gender:** ☐ M ☐ F ☐ Other ***Date of Birth:** ___/___/____

Social Security #: _____ Secondary ID: _____ Medicare #: _____

Last Name: _____ First Name: _____ Middle Name: _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

***Blood Group:** ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ Blood type not done
☐ Transitional ABO / Transitional Rh ☐ Transitional ABO / Rh + ☐ Transitional ABO / Rh -
☐ Group A/Transitional Rh ☐ Group B/Transitional Rh ☐ Group O/Transitional Rh ☐ Group AB/Transitional Rh

## Patient Medical History

List the patient's admitting diagnosis. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: _____ Description: _____
Code: _____ Description: _____
Code: _____ Description: _____

List the patient's underlying indication for transfusion. *(Use ICD-10 Diagnostic codes/descriptions)*

Code: _____ Description: _____
Code: _____ Description: _____
Code: _____ Description: _____

List the patient's comorbid conditions at the time of the transfusion related to the adverse reaction. *(Use ICD-10 Diagnostic codes/descriptions)* ☐ UNKNOWN ☐ NONE

Code: _____ Description: _____
Code: _____ Description: _____
Code: _____ Description: _____

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# Transfusion Associated Dyspnea

List the patient's relevant medical procedure including past procedures and procedures to be performed during the current hospital or outpatient stay. *(Use ICD-10 Procedure codes/descriptions)* ☐ UNKNOWN ☐ NONE

Code: _____ Description: _____

Code: _____ Description: _____

Code: _____ Description: _____

Additional Information _____

## Transfusion History

Has the patient received a previous transfusion? ☐ YES ☐ NO ☐ UNKNOWN

Blood Product: ☐ WB ☐ RBC ☐ Platelet ☐ Plasma ☐ Cryoprecipitate ☐ Granulocyte

Date of Transfusion: ___/___/____ ☐ UNKNOWN

Was the patient's adverse reaction transfusion-related? ☐ YES ☐ NO

If yes, provide information about the transfusion adverse reaction.

Type of transfusion adverse reaction: ☐ Allergic ☐ AHTR ☐ DHTR ☐ DSTR ☐ FNHTR ☐ HTR ☐ TTI ☐ PTP ☐ TACO ☐ TAD ☐ TA-GVHD ☐ TRALI ☐ UNKNOWN ☐ OTHER Specify _____

## Reaction Details

***Date reaction occurred:**___/____/____ ***Time reaction occurred:** __ __:__ __ ☐ Time unknown

***Facility location where patient was transfused:** _____

Is this reaction associated with an incident? ☐ Yes ☐ No If Yes, Incident #: _____

## Investigation Results

* ☐ **Transfusion associated dyspnea (TAD)**

***Case Definition**

**Check all that apply:**

☐ Acute respiratory distress occurring within 24 hours of cessation of transfusion.

☐ Allergic reaction, TACO, and TRALI definitions are not applicable.

Other signs and symptoms: (check all that apply)

| | |
|---|---|
| Generalized: | ☐ Chills/rigors ☐ Fever ☐ Nausea/vomiting |
| Cardiovascular: | ☐ Blood pressure decrease ☐ Shock |
| Cutaneous: | ☐ Edema ☐ Flushing ☐ Jaundice ☐ Other rash ☐ Pruritus (itching) ☐ Urticaria (hives) |
| Hemolysis/Hemorrhage: | ☐ Disseminated intravascular coagulation ☐ Hemoglobinemia ☐ Positive antibody screen |
| Pain: | ☐ Abdominal pain ☐ Back pain ☐ Flank pain ☐ Infusion site pain |
| Renal: | ☐ Hematuria ☐ Hemoglobinuria ☐ Oliguria |
| Respiratory: | ☐ Bilateral infiltrates on chest x-ray ☐ Bronchospasm ☐ Cough ☐ Hypoxemia ☐ Shortness of breath |

☐ Other: (specify) _____

***Severity**

Did the patient receive or experience any of the following?

☐ No treatment required ☐ Symptomatic treatment only
☐ Hospitalization, inlcuding prolonged hospitalization ☐ Life-threatening reaction
☐ Disability and/or incapacitation ☐ Congenital anomaly or birth defect(s) of the fetus
☐ Other medically important conditions ☐ Death ☐ Unknown or not stated

***Imputability**

Which best describes the relationship between the transfusion and the reaction?

☐ Patient has no other conditions that could explain symptoms.
☐ There are other potential causes that could explain symptoms, but transfusion is the most likely cause.
☐ Other present causes are most likely, but transfusion cannot be ruled out.
☐ Evidence is clearly in favor of a cause other than the transfusion, but transfusion cannot be excluded.
☐ There is conclusive evidence beyond reasonable doubt of a cause other than the transfusion.
☐ The relationship between the adverse reaction and the transfusion is unknown or not stated.

Did the transfusion occur at your facility? ☐ YES ☐ NO

## Module-generated Designations

*NOTE: Designations for case definition, severity, and imputability will be automatically assigned in the NHSN application based on responses in the corresponding investigation results section above.*

***Do you agree with the *case definition* designation?** ☐ YES ☐ NO
**^**Please indicate your designation _____

***Do you agree with the *severity* designation?** ☐ YES ☐ NO
**^**Please indicate your designation _____

***Do you agree with the *imputability* designation?** ☐ YES ☐ NO
**^**Please indicate your designation _____

## Patient Treatment

Did the patient receive treatment for the transfusion reaction? ☐ YES ☐ NO ☐ UNKNOWN

If yes, select treatment(s):

☐ Medication *(Select the type of medication)*

☐ Antipyretics ☐ Antihistamines ☐ Inotropes/Vasopressors ☐ Bronchodilator ☐ Diuretics
☐ Intravenous Immunoglobulin ☐ Intravenous steroids ☐ Corticosteroids ☐ Antibiotics
☐ Antithymocyte globulin ☐ Cyclosporin ☐ Other

☐ Volume resuscitation (Intravenous colloids or crystalloids)

☐ Respiratory support *(Select the type of support)*

☐ Mechanical ventilation ☐ Noninvasive ventilation ☐ Oxygen

☐ Renal replacement therapy *(Select the type of therapy)*
☐ Hemodialysis ☐ Peritoneal ☐ Continuous Veno-Venous Hemofiltration
☐ Phlebotomy

☐ Other Specify: _____

## Outcome

***Outcome:** ☐ Death ☐ Major or long-term sequelae ☐ Minor or no sequelae ☐ Not determined

Date of Death: ____/____/_____

^If recipient died, relationship of transfusion to death:
☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled Out ☐ Not determined

Cause of death: _____

Was an autopsy performed? ☐ Yes ☐ No

## Component Details

***Was a particular unit implicated in (i.e., responsible for) the adverse reaction?** ☐ Yes ☐ No ☐ N/A

| Transfusion Start and **End Date/Time** | ***Component code** (check system used) | Amount transfused at reaction onset | ^Unit number (Required for Infection and TRALI) | ***Unit expiration Date/Time** | ***Blood group of unit** | **Implicated Unit?** |
|---|---|---|---|---|---|---|
| **^IMPLICATED UNIT** | | | | | | |
| ____/____/___ ___ ___:_____ ____/____/___ ___ ___:_____ | ☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____ | ☐ Entire unit ☐ Partial unit _____mL | __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ | ___/___/_____ _____:_____ | ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A | Y |
| ____/____/___ ___ ___:___ _ ____/____/___ ___ ___:_____ | ☐ ISBT-128 ☐ Codabar ___ ___ ___ ___ ___ _____ | ☐ Entire unit ☐ Partial unit _____mL | __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ | ___/___/_____ _____:_____ | ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ N/A | N |

## Custom Fields

| Label | | Label | |
|---|---|---|---|
| _____ | _____/_____/_____ | _____ | _____/_____/_____ |
| _____ | _____ | _____ | _____ |

## Comments